COMMUNITY BASED HEALTH/NUTRITION EMERGENCY PREVENTION PROJECT

MALANJE, ANGOLA

Final Report

November 2002 – April 2004

Submitted by Concern Worldwide

I. Executive Summary

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Program Title: Community Based Health/ Nutrition Emergency Prevention

Grant number: HDA-G-00-02-00063-00

Country/ Region: Angola/ Malanje Province

Disaster/Hazard Chronic Emergency

Period of Activity: November 1, 2002 – April 30, 2004

Summary of Activities:

Over the entire grant period activities progressed from implementation of curative nutritional support and the formation of community health care volunteers (CHVs) to the closure of these centers and the increased focus on the work of the CHVs and nutritional monitoring. The situation in Malanje, as with the rest of the country, has altered significantly since this program started. The country has gone from a time of full scale war to a state of peace, which hopefully will last. The activities of the programs were altered at many and various stages to meet the needs as posed by the community**.** All adjustments were done with the knowledge of the donors, and documented in the quarterly reports.

During the last three months of the program the team evaluated the project and completed all remaining activities in order to meet the objectives before the project's end. Initiatives such as the First Aid training and implementation proved valuable, as did the provision of first aid kits to each CHV.

The fight against Malaria is ongoing. The selling of the mosquito nets as directed by both WHO and the MoH was slower than anticipated, but was none the less very successful in helping address the issue of Malaria prevention. A big effort was also placed on malaria prevention through education, environmental and vector control, hygiene and sanitation.

During this last phase there was also a direct focus on nutrition, the prevention of malnutrition and the benefits of breastfeeding and weaning practices. These educational sessions were participative and provoked a lot of discussion with the groups within the communities.

The outreach team continued to monitor the population, especially the known vulnerable groups within the communities.

Current situation

The overall situation in Malanje province has improved drastically over the project period. When this program started in 2001 access was available to only three municipalities and the MoH supported health facilities could only be found in these locations. Currently, at the provincial level, there are 25 operational health centers. These facilities have fixed vaccination posts, in-patient facilities, 24 hour care, emergency facilities and maternity facilities. The provincial hospital is constantly being upgraded and provides a back-up service to the health facilities in the province. A new maternity wing with facilities for 50 beds has recently been opened and is being well utilized by the women of the city. The hospital is currently staffed by a team of Korean doctors and 5

Angolan doctors. In 2001 there were no Angolan doctors available to work in the hospital.

In 2001 the number of mine related incidents in the province was one of the highest in the country. According to the Norwegian People's Aid group, there were no reported incidents in Malanje in 2003 and only some isolated incidents so far in 2004.

Vaccination levels are still not as high as desired. The lack of access to some areas, due to poor roads and bridges has hampered efforts. In the accessible areas, Measles coverage as high as 92% has been achieved.

There is currently no NGO working in nutrition, but many of the NGOs are carrying out health projects. MSF- Holland has four STD, HIV/AIDS treatment centers in Malanje city. GVC (Italian NGO) support traditional birth attendants in Calandula and Cacuso.

II. Program Overview

A. Program Goal

To contribute to the reduction of mortality and morbidity in a chronic emergency situation by increasing the capacity and capability of communities to prevent diseases and malnutrition and improve the utilization of available basic health facilities. (In accordance with the protocol of MOH-Angola)

B. Objective

Improve capacity of Malanje Ministry of Health to promote health through community outreach, nutritional support, nutritional surveillance and coordination of all actors involved in providing health services in Malanje.

III. Progress towards the Objective:

The ultimate combined objective of this program was to provide a service to the population that is effective, efficient, sustainable and economic. The whole team has worked immensely hard over the reporting period in an attempt to achieve this while taking into consideration the changing environment and other problems faced by the communities. This has been achieved through ongoing information collection and project evaluations. They have also collaborated with other groups in the communities, e.g.

Oxfam's water and sanitation groups and with other health activities, such as the provision of routine vaccinations.

At the central level the Concern team has been very active in participating in coordination meetings held on a weekly basis by OCHA, for general coordination, and with the health sub-group with the MoH on a monthly basis. Over the course of the project Concern has directly participated in eight rapid needs assessments and has trained the MoH team to continue to carry them out. Concern has also been one of the main leaders in conducting nutritional surveys.

The team participated in the planning of the project at every step, with the CHVs being a key group in this planning process. In terms of meeting the overall objective, while recognizing that the MoH capacity remains weak, some advances have been made. Some problems are inherent in the operation of the MoH, including the lack of funding and resources which leads to the lack of capabilities and motivational problems among the staff. However there is a great interest in the activities that Concern has implemented and the MoH have been included in all steps of the project. The MoH have assumed responsibility for carrying out nutritional surveillance through monthly statistic monitoring of SFCs and conducting rapid assessments. Coordination improved over the course of the project. Concern participated in monthly Governmental sub-group meetings with the MoH and all other NGOs working in Health in the province.

See the Appendices for the Logical Framework.

IV. Indicators and Current Measure:

The result of the quality of work of the CHVs is seen in a marked reduction in malnutrition and morbidity levels now seen in Malanje city and its peripheries. The last data collected with relation to this was in June 2003 and the results included the following:

Global Malnutrition – 2.75 z-score
Crude Mortality Rate – 0.7/10,000/day
Overall morbidity – this rate has drastically reduced. Although no accurate figures exist, in collation of the malaria statistics, it is estimated that the rate of morbidity was reduced up to 12% in most of the areas where the CHVs work.
Admission rate the feeding centers – reduced to 18 cases on average a month to TFC and SFC.
Measles coverage – The rates are much higher within the city limits and the areas where accessibility is easier. Unfortunately there still exists small pockets of populations, especially to the north of the province where the coverage is considered grossly inadequate. Rates are as high as 92% in the city areas, with ranges from 46.2 % (Marimba, north of province) to 70.4 % (Quirima, south of province).

C. Target Population and Critical Needs:

i. Target Population:

The project target population is 100,000 covering vulnerable children ages 0-5 years, pregnant and lactating women and men who are targeted for certain sensitization and awareness campaigns in the city of Malanje. These populations are residents of the city and also displaced populations who have resided in the city for a period of years due to civil conflict/war.

Priorities are given to children ages 0-5 years and pregnant and lactating women with special health and nutrition needs.

The target population has not changed over the course of the program. However, some of the zones have had an increase in their population size. The population figures are reported by the traditional leaders and are the numbers used by the Government. There has been huge population movement since the war ended, but this seems to have currently settled, according to both MINARS (the Department of Social Services) and OCHA.

ii. Critical needs:

a. Infant and child mortality rates in Angola are the second highest in Africa, 295/1000, and Malanje Province has some of the highest rates within Angola.

b. A November 2002 cluster survey showed that *under five mortality rates* in Malanje Town were 3.35/10,000/day with *crude mortality rates* of 1.52/10,000/day. The next survey was conducted in June 2003 showing a decrease in *mortality rate* of 2.02/10,000/day and crude mortality rate of 0.70/10,000/day. Another survey has not yet been conducted.

c. Maternal mortality is abnormally high at: 3,414/100.000 i.e. One in every 300 women dies in child birth.

d. The lead causes for deaths were all preventable illnesses, including Malaria, diarrheal diseases and respiratory chest infections.

e. A vaccination survey[1] showed that only 19.3% of the children were fully immunized and of the mothers only 26.4% had received the appropriate vaccination.

[1] IMC, Immunization Coverage Survey, Malange and Lombe, November 2000

These were the current figures on which the activities of the program were based. More recent figures released in the UNICEF MICS study of 2003 reports in Angola infant mortality at 150/1000 and under 5 mortality at 250/1000. Malanje, along with other areas in the northern region of Angola, continues to report slightly higher rates - infant mortality rates of 156/1000 and under 5 mortality rates of 262/1000.

D. Geographic location

Planned:

Eighteen (18) *Bairros* of Malange City and Lombe, Cacuso in the province of Malange, Angola.

Actual:

Eleven (11) *Bairros* of Malange City. Cacuso, in Lombe is one of the areas where the traditional leaders were unwilling to support the scheme. The CHVs are working in 12 separate zones within these locations. Most *bairros* are subdivided into zones depending on their size and population.

E. Program Performance

a) Actual Accomplishments:

i. Information Gathering and Baseline Data

The community health volunteers reached the objectives set out in the project proposal by performing the following tasks:

- Nutritional screening using MUAC measurement, and referral of malnourished children and adults. Priority attention was given to children who were being weaned or were recently weaned, and children who had recently started school, as these groups are known to be vulnerable at these stages in life.
- Pregnant and lactating women were screened and referred if indicated, particularly if the pregnancy occurs in girls less than 18 years old.
- Educational sessions were the key tool used to disseminate information to the population. Through sensitization the population was mobilized to take responsibility over the health and nutritional issues they could control. These sessions gave them the motivation and tools to improve their individual health and that of their families and communities.

The CHVs continued to collect data with relation to the morbidity, mortality, nutritional status and other useful information with regard to the general well being of the communities.

ii. Nutrition and Outreach Workers

Some of the problems that the CHVs reported after conducting some of their education sessions in the community were:

- The common misconception that if a woman was pregnant with one baby, yet breastfeeding another, that the baby she was carrying would poison the baby at the breast.
- Traditionally it is uncommon to give the first milk colostrums (thin, clear fluid) to the new born baby as the thinking is it is not milk.
- During this time while the mother waits for the milk to change she gives the baby water or other fluids with traditional herbs and roots.

With this and other specific information of what the CHVs were encountering, training was tailored to suit the specific needs of the communities. The CHVS were able to learn for themselves which enabled them to teach their own communities.

The CHVs remained vigilant throughout the program, particularly in relation to the coping skills of the population to maintain adequate nutritional status. Over time the amount of land accessible to the population rose significantly. Massive mine clearance was achieved by the Norwegian People's Aid (NPA), allowing a wider degree of accessibility to the general population. With this positive development came an increased need for seeds and tools, so Concern set up an agricultural program in Malanje which ran through July 2003.

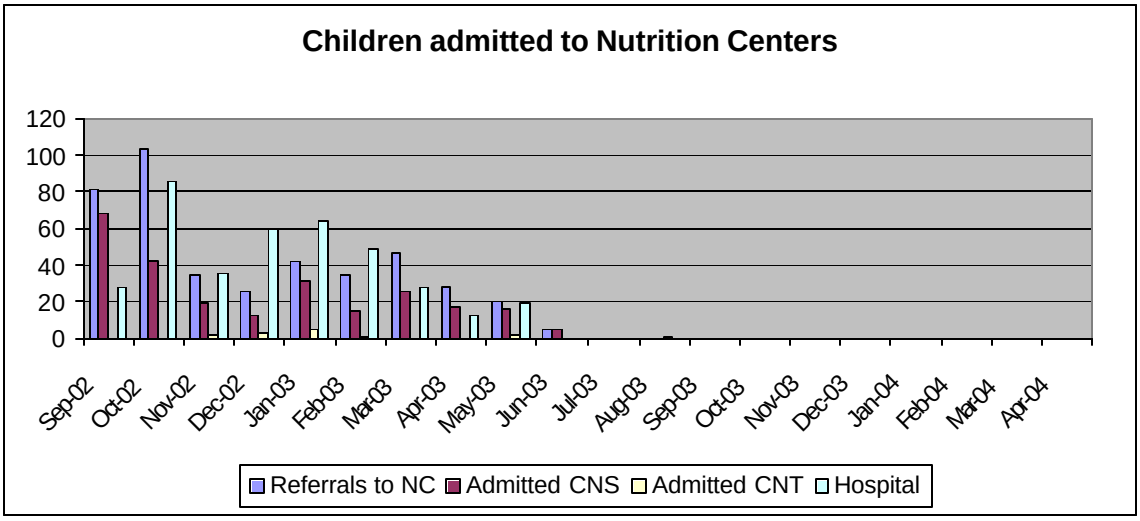
Unfortunately in late 2003 and early 2004 the rainy season was particularly heavy. To date the full impact of the heavy rains is not fully known. As many of the farmers were able to harvest some of their crops it is only when their stocks run out that the true situation will become clear. For the month of April a small rise in market prices was noted for the average food basket, but not a substantial one. This is seen as a good indicator of the communities' ability to cope with the evolving situation.

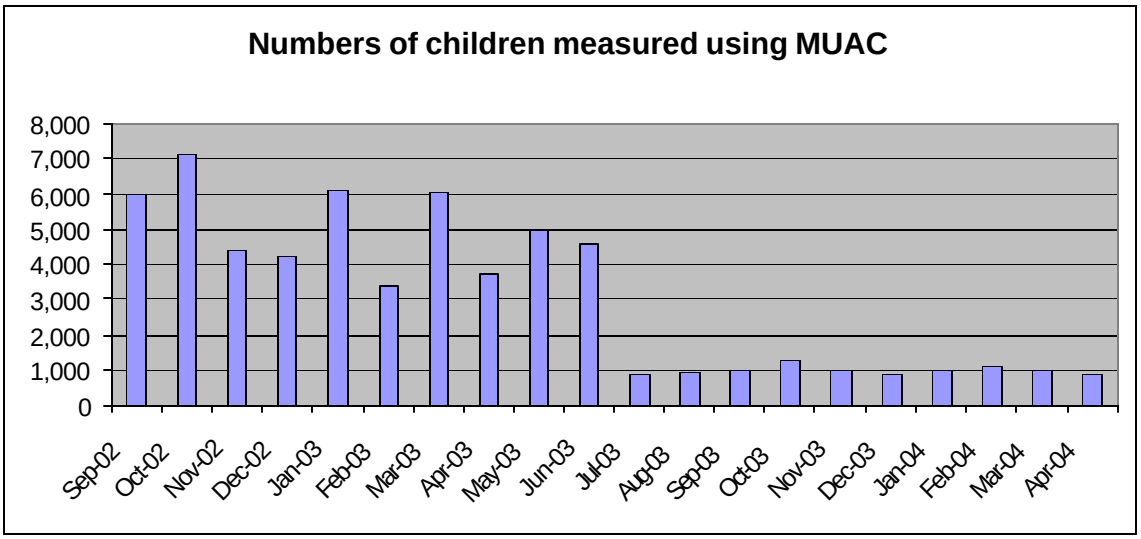
The continued increase in access to more of the province and indeed to the rest of the country has had a very positive effect on the lives of the population. From when the cease-fire was signed in April 2002 after the UNITA rebel leader Dr. Jonas Savimbi was

killed, population movement increased. With this increase in movement came more products and more opportunities to cope and survive.

The CHVs have been a crucial part of the evolution of the communities to cope with all these changes. The change towards a more sustainable lifestyle did not automatically bring about an improvement in the population's health and nutritional status. The CHVs worked very hard in teaching people that if there was now extra money it was better to buy certain food stuffs or storage facilities rather than buy beer, as was the current practice.

Below are the graphs from September 2002 to April 2004. The numbers of children admitted to nutrition centers dropped significantly, indicating the obvious reduction in outward signs of malnutrition. The numbers of children referred to the nutrition centers went down to zero at times during the project. Since August 2003 only one child has been found that required transferal to a feeding facility. The numbers of children that the teams are measuring also fell dramatically over the course of the project.





The graph show the numbers of children that the Out Reach Team referred to Nutritional centers of various types. Only one child was referred in August and no further referrals have been carried out since. The numbers of admissions in the Therapeutic centers is on average 8 per month for the past nine months.

iii.. Nutritional Assessments

Over the course of the project time frame Concern participated in eight rapid needs assessments organized by OCHA. The team also trained the MoH team who currently carry out the nutritional aspect of these assessments. Concern has also conducted two anthropometric surveys, a baseline and a KAP study (Knowledge, Attitude and Practice).

Concern conducted two Nutritional surveys over the course of this project. The results as outlined below indicate a positive improvement.

Malanje	Nov-02		Jun-03	
Indicator	**Result**	**95 % CI**	**Result**	**95 % CI**
Global Malnutrition (Z-score <-2 or edema)	2.64	0.63 – 4.63	2.75	0.09 – 5.41
Severe Malnutrition (Z-score <-3 or edema)	0.81	0 – 1.93	0.34	-0.61 – 1.30
Crude Mortality Rate (measure in /10,000/day)	0.24	0.31 – 0.79	0.7	0.30-1.10
Under-5 Mortality Rate (measure in /10,000/day)	1.18	0.50 – 1.86	2.02	0.70 – 3.34
No Measles Vaccination (%)	25.1	-	2.8	0.1 – 5.5
Vaccination confirmed with card (%)	35.4	-	86	80.3 – 91.7
Vaccination not confirmed (%)	39.5	-	11.2	6.0 – 16.4

Lombe	Nov-02		Jun-03	
Indicator	**Result**	**95 % CI**	**Result**	**95 % CI**
Global Malnutrition (Z-score <-2 or edema)	5.45	2.45 – 8.45	2.48	0.43 – 4.53
Severe Malnutrition (Z-score <-3 or edema)	1.36	0 – 2.86	0.45	-0.43 – 1.33
Crude Mortality Rate (measure in /10,000/day)	0.3	0.07 – 0.53	0.6	0.17-1.03
Under-5 Mortality Rate (measure in /10,000/day)	1.6	0.64 – 2.74	1.58	0.26 – 2.90
No Measles Vaccination (%)	31.1	-	2.6	0.5 – 4.7
Vaccination confirmed with card (%)	29	-	85.8	81.1 – 90.5
Vaccination not confirmed (%)	39.8	-	11.6	7.3 – 15.9

The KAPS survey carried out at the beginning of the project timeframe, included the collection of data in relation to; household information, water and sanitation, treatment of illness, reproductive health, vaccinations, malaria, contraceptive use, HIV/AIDS and nutrition. It formed the baseline for the design of interventions. (see report annexed)

To date no anthropometric survey has been conducted since the Concern survey in June 2003. MoH claim to have plans to carry out a survey but as yet nothing has happened. This has been discussed with the provincial delegate for health who cited many different

reasons for not conducting the survey, such as the general situation obviously improved, there are not enough financial resources to fully realize a survey and that the people trained to conduct this type of study are now based in Luanda. Concern offered to assist in any way necessary.

B. Program Progress by Output

Output 1. *Improved capacity of the MoH in Malanje to support and develop the work of their CHWs at a satisfactory professional working level.*

This capacity, as initially perceived possible when the project started, has proven to be very difficult to attain. When the project was conceived in 2000, the idea to form and support the CHVs was exactly in line with the MoH strategy. Since that date the MoH strategy has been altered. The current strategy still includes the CHVs but not to the extent first planned. No one individual in the MoH in Malanje is appointed the absolute responsibility to be in charge of such a division. In overcoming this constraint the team worked with the relevant departments - from the epidemiological to the malaria team. Although it has not always been possible to advance in quite the way planned, the degree of flexibility and ingenuity demonstrated by the various members of the team has been remarkable.

Which ever department was responsible, efforts have been made to ensure that MoH have been involved at every step of the planning and implementation of the project. The capacity with the above constraints has been limited but it has occurred to some degree.

At a local level there has been more marked success. The community feel a sense of ownership with relation to the health facilities in their areas. As such they are happy to be involved in the activities of the health posts. The CHVs are now seen as a bridge between the community and the MoH workers in the posts. The relationship that has been built up between the two sides has been tentative but is strengthening every day. Sustainability of the CHVs; the aim of the practicality of the incentives offered to the CHVs over the course of the project timeframe was to improve their capacity to be sustainable in the absence of Concern's support. Most of the incentives offered to the CHVs were discussed with them during the planning phases to identify what would be of most value to them in the long term. They were participative in selecting what they would receive. Through the use of the equipment supplied to them they will be able to continue their work as a CHV, while also maintaining a capacity to be self-sufficient and provide for their family unit. The continued sustainability may also be positively influenced by the good relations between the CHVs, the community and community leaders.

Output 2. *Revitalized and improved capacity of community health workers, according to the Angolan MoH strategy.*

As stated above, the MoH revised its strategy with relation to community health not long after the commencement of this project. Concern decided to continue with the original idea and the project advanced. When the project was being elaborated, the MoH decided to make health promoters a major part of their intervention in the communities. By the time the project came to fruition, the MoH indicated they had not enough financial or human resources to support this, and thus they cut the intervention from their list of priorities. Following this decision, Concern met with the MoH and with them decided to continue with their plan. The CHVs were elected from within their own communities by their own communities to work in their communities. In the area where this worked they were well supported by the traditional leaders, *Sobas* and by the community themselves.

Unfortunately there was not support from all the planned areas of intervention. The original plan to have 60 CHVs in 18 different areas was soon revised when it became obvious through initial contacts that this idea was not acceptable to all. 38 CHVs were eventually found and trained in 12 zones of different *Bairros.* One of these individuals has left the program as he got a salaried job. Another idea then developed - to pay them as an incentive. When Concern planned this project, they were the only NGO in the area with this type of outreach team. Very quickly many of the other NGOS also began to use outreach teams and not all had the resources to be able to pay them as Concern had planned. A meeting was held with the MoH and together it was decided that it was better to give the money in kind, but in a realistic fashion so as not to tip the balance of the initiative and improve sustainability. In trying to decide what type of incentives to give, certain parameters were decided upon. It was decided not to give too much or too many items, thus making it more difficult for other agencies working in the same type of field to compete. Possible goods to be given were discussed with the CHVs themselves, as were other expenditures. The incentives given over the course of the program included; Bicycles, Hand Carts and a full agricultural/hygiene kit, soap and a MoH reference manual, all of these were decided upon jointly but with sustainability in mind. The CHVs need to be able to take the time necessary to carry out their work while also retaining a capacity to be self sufficient themselves.

The training that was designed was a flexible year long plan. Initially they received a broad general training to give them a good overview, then at periodic points along the time scale other specific trainings were held, e.g. in relation to hygiene.

These trainings were planned with the relevant department of MoH, and the existing MoH manual was used to guide the training. The final training given re-enforced many of the messages given in the original trainings, but also had a strong malnutrition

prevention aspect. At the end of the training each CHV was presented with a copy of the MoH Health Promoter Manual, which their trainings to date have been based on. Many of the NGOs currently working in Malanje are now using outreach of some type to reach a wider community base and to be more participative, although none have the broad role that these CHVs have had.

Output 3. *Continued delivery of curative nutrition care for malnourished children in Malanje and newly accessible areas, subject to assessments.*

From the first months of the project the numbers of beneficiaries at the nutrition feeding center and the indicators of malnutrition began to drop in Malanje. Peace came very quickly after 26 years of war in April 2002 and the impact was seen suddenly. As can be noted in by the nutritional survey results, (see fig 3), the situation stabilised by May of 2003 and by the end of June a full hand over of the curative supplementary center to MoH was achieved. The Government continues to run both the therapeutic and the supplementary center, the food is being supplied by WFP. The numbers of admissions there too have fallen and most of the under-5 year olds admitted have been referred from the peripheries of Malanje province.

Concern continued to give technical advice and support to the centers. Their numbers continue to be very low, although there was a small rise in March. This could be due to the impact of the rainy season. In Malanje some crop destruction was seen due to heavy and unseasonable rains, shortly after the seeds were planted.

Case Study: Carlos is now 10 years old. When he was five he was first admitted to the Concern SFC, as he was moderately malnourished. His family had recently arrived in Malanje city from outside the security zone. He received treatment in the center and was discharged. Unfortunately he became malnourished again when his father died and had to be re-admitted to the SFC in June 2002. During this admission his mother received seeds, which he and his two brothers helped her plant. He really liked working in the garden and when they harvested the crop, they had enough for themselves and some to sell. He collected the seeds and planted them again. His family now have a wonderful garden he says. He goes to school and brings his friends home to see his garden. His family use the crops themselves but are also able to live off what they sell. He feels that because of Concern his whole family have a future.

Output 4. *Increased health/nutritional knowledge amongst the population through participatory and practical health/nutrition education.*

The CHVs refined and tailored education to suit the needs of the community and the individual. Mother and child groups were called together to impart information about

infant feeding, the importance of breast feeding, weaning, vaccination etc. Clean delivery discussions were held with groups of pregnant women, while information dissemination about hygiene and sanitation were aimed at everyone.

During formal and informal visits to the field, questions posed to the community were always met with answers. If necessary, the CHV would intervene with a one on one session. As a result of their work there were most notable improvements in relation to how malaria is transmitted and prevented. In theses areas there still exists a lot of traditional beliefs as to how malaria is contracted, thus the constant impartment of the same message has begun to take affect. As part of the verification of this point is the success the team have had in selling mosquitoes nets as part of the WHO and MoH initiative to combat Malaria. The CHVs acted as agents for this campaign, and the money gained from selling the nets is returned in full to MoH who then return the money to the fight against malaria process.

The impact of the increased knowledge within the communities is visible. The areas where the CHVs work, show significant improvements in its physical aspect, both in relation to a comparison from before the project started and in comparison to its neighboring area.

Accepting that malnutrition is a multifaceted problem, the overall aim to target prevention of the issue, also needed to be multifaceted. The CHVs worked on many of the causes of malnutrition, by improving health, raising hygiene awareness, the importance of sanitation, as well as the importance of a balanced diet. Other methods used were the facilitation of discussions, raising of questions, and the formation of relationships between communities, especially women, with the aim of supporting each other.

Case Study: Maria Ngeve is 28 years old and has just 4 children who are alive. Her other 3 children and her husband have all died because they did not have enough food she says. Her neighbour's children attended the Concern SFC in Malanje. Her neighbour asked her to come with her to hear the CHV give an education session in their own zone. She was amazed to learn that children who stop breastfeeding are very vulnerable and that you can continue to feed even if you are currently pregnant. She now attends as many of these sessions as she can and often tells her sister in Cangandala of the things she has learned. One day she even accompanied the CHV on her normal work day in the zone, talking to lots of the mothers about nutrition and vaccination. She says that she is much more aware now of the food she gives her family, of how she stores it, of how she prepares it and even of what she buys. She says she is amazed that there is so much to remember, but she works really hard at this for her sons. She believes that the CHV has given her family a very precious gift - knowledge.

Output 5. *Improved co-ordination of community based health assistance provided to the community.*

Weekly meetings were held with the CHVs themselves. This assisted in resolving any problems, clarifying any issue and gave a chance for the CHVs to come together as a group and to form some type of cohesion. This helped them to interact together. In forming these relationships with each other they were able to use the other members of the group to help them. This became a type of peer support. Activities were coordinated with the Concern health team, supervisors and CHVs. This included planning of daily activities and the carrying out of supervision visits to the areas in which the CHVs carry out their work. The CHVs from one area met each morning with a supervisor present and discussed the daily needs for their own area.

On a monthly basis, the supervisors participated in the MoH health sub-group meeting. This was an opportunity to co-ordinate activities, disseminate information, or to resolve any other standing issues. Special meetings were also held when necessary to treat any specific issues, e.g. an out break of measles. As stated above, the MoH coordinated the meetings and the overall provincial activities.

Concern also participated in the weekly OCHA coordination meeting. This included all NGOs actively working in the province and gave broad overall information about issues that affect the population and NGO community as a whole. Issues such as the peace process, security, IDP movement and conditions were frequent topics.

Other specific issues such as water and sanitation were discussed on a more one to one basis with the relevant group.

Monthly reports and statistics with analysis were provided to the MoH and any other partners interested.

Output 6. *Strengthened nutritional/food security surveillance system through a permanent outreach team.*

The early warning system provided by the outreach team and the CHVs in monitoring the nutritional status of the population in Malanje was crucial over the project period. When the decision was made to close the feeding centers in Lombe and Malanje, in April and June 2003 respectively, the decision was taken looking at a multitude of information. This information included the analysis of the center data, the results of the nutritional surveys but also on the information being tabulated as a result of the MUAC screenings and other pertinent information gathered by the teams. MUAC screening continued on a monthly basis. In January 2004, a total of 1,304 children had MUACs carried out by the CHVs in the community. Of this number there were no referrals to the MoH centers, this can be related to the improved knowledge, practices and earlier identification of malnutrition in the population that the CHVs work with. After the centers had been closed, the team continued their activities and monitoring capacity.

The small kitchen gardens were set up, with each of the CHVs receiving seeds as specified. These seeds were purchased from a reputable dealer with the assistance of the Concern Food Security Project Manager. This was done to assure resistance to pests and to attempt to ensure the outcome of the harvest.

During the time of the feeding centers the beneficiaries received vegetable seeds, as planned. These tended to be the most vulnerable of the population. The intervention was done as a full process. The Concern Food Security team assisted the Nutrition team in providing education sessions to the beneficiaries. This was all done in stages. From their experience it has been noted that some of the farming skills have been lost in the population for many reasons. People have had to move for decades so had no time or resources to plant and information was lost. It was, therefore, decided to have the most effective impact; Concern would re-teach some of these fundamental skills by using a test plot at the feeding center. A portion of land at the feeding center was allocated to growing the crops, and then on a weekly basis the beneficiary learned what needed to be done in order to have a good harvest. A general education session was first given as to why Concern felt it necessary to give the seeds, when one needed to eat vegetables, and the effect of not doing so. The land at the center was prepared in weekly sessions with the beneficiary group. Once the seeds were actually distributed the preparation process had been completed, the CHVs had visited many of the homes to ensure the beneficiaries had completed the tasks necessary to sow their seeds. Follow up was also done. This showed a variance of results. Some of the beneficiaries complained that their crops had been stolen, other harvested too early while more sold their crop for cash.

Many others reaped a good harvest and were able to benefit for the crop. Some are still growing crops with the seeds gained from the original crop.

Fruit trees were planted in communal areas, at schools, water points, churches, etc. As a result, everyone had access to all the amenities. As the saplings have only been planted in the past season, the first fruits will not be expected until 2005. The fruits can then be picked and consumed directly from the trees.

The main focus of this input over the latter part of the reporting period has been on education. Vulnerability among the target population remains an issue. Although peace has brought stability, it is still a fragile process for the greater population. People's coping skills have improved. Their usage of the information they have received and will continue to receive from the CHVs has been a critical part of this adjustment.

C. Unforeseen Circumstances

i) i. *Unexpected Delays*

There were many and variable constraints associated in getting this project to its conclusion. Unforeseen problems, such as the restrictions that came from the lack of MoH support, required much negotiation in order to move forward. Additional challenges to the program included:

- A lack of support for the activities originally planned by certain traditional leaders and thus some communities.
- The delay in getting the mosquito nets to the province and then having to have them all impregnated.
- Change in Government policy was not foreseen when writing the proposal, to not include CHVs as a priority for the coming years.
- Including Mabendazole in the First Aid kits caused the Provincial delegate to block the use of the kits. This was then resolved in January when he was approached with an amended format.

Throughout all of these problems and constraints, Concern and the team remained flexible and were able to come to some sort of agreement or compromise to effectively and efficiently achieve the objectives of the project while not compromising the specific outputs. The no-cost extension sought from December 03 – April 04, was an action undertaken to help this program meet its objectives and come to the fruition planned from the outset. As the project was late starting and then met with some unforeseen delays, i.e. the alteration of the MOH strategy, it was felt that a no cost extension was necessary to fully realize the activities of the proposal.

VII. Resource Use/Expenditures

A total of US$ 349,821, 100% of the budget has been spent to date

The original budget was made based on the original plan, which was to include incentives for the CHVs. When this became a non-issue due to the NGO community and MoH request to alter this activity, the spending of this budget line became more difficult, however following discussion with the donors this was resolved.

The no cost extension applied for in November also included a budget revision, which was approved in mid December. The spending during this time was directed to buy the CHV team clean kits for themselves and one for each community. These were witnessed being used on subsequent supervisory visits. Each CHV received a bicycle, a goat and, after they finished their training on First Aid, also received a first aid kit with a supply of stock goods to help them in the future. They also received the seeds which they have planted and the fruit trees. Each got a copy of the MoH training manual in their last training.

Each traditional leader and his deputy were also given a bicycle to assist them in their vigilance with regard to the Environmental health activities. Again this was witnessed to be working. When visiting the project site the Assistant Country Director met one *Soba* cycling to the hand pump to ensure it had been properly cleaned during use, before he cycled off to the education session being given on bed net usage by the CHV. The CHVs have stated that the level of participation and attendance since the local leaders received the bicycles has increased hugely. Members of the population commented on this also. Some monies were used to repair the hand pumps and drainage areas of pumps in the project areas in collaboration with Oxfam. A supply of soap has been given to each CHV to ensure they are able to continue with their work in promoting hygiene and sanitation. The soap distributed was sufficient for distribution in the community as an aid to hygiene lessons and also sufficient for the CHV to maintain their own hygiene needs.

The team also gave some tables and chairs to the health facilities to assist them in their work. Some plastic sheeting was also bought, which was used to provide cover to some of the communal latrines in the zones.

Evaluation

In March 2004, an external evaluation was carried out by Consaude. A copy of this report is annexed to this report. Overall the findings were very positive with helpful and useful recommendations for future projects.

Annexes

Summary of Project Activities

11/2002 – 4/2004

1st Quarter	**November to January**	**Date-line**
Staffing issues	Staff interviews and hiring. Restructuring of existing staff.	November to January
Base line survey	900 women interviewed about their Knowledge, attitudes and practices relating to health	* November 2003
SFC Malanje and Lombe	Nutrition centers continued their normal activities. Beneficiaries numbers fell	November to January
Nutrition survey	Malanje Lombe Global Malnut (z-score) 2.64 5.45 Severe Mal (z-score) 0.81 1.36 CMR (/10,000/day) 0.24 0.30 <5 MR (10,000/day) 1.18 1.60	November to January
Rapid assessments	Concern participated in two rapid assessments to areas in Caculama. 230 children in total are measured using MUAC. No intervention necessary for nutrition	November to January

2nd Quarter	**February to April**	
Participatory Rural appraisals	Twelve PRAs in different areas of the community were carried out.	Feb to April
CHV	Selection was completed, trainings commenced	Feb to April
CHV activities	The CHVs began their work in the communities.	*March 2003
SFC Lombe	Closed due to falling numbers	April 31st 2003
SFC Malanje	Numbers continue to fall	Feb to April
Rapid assessments	Concern participated in 6 rapid assessments to the areas of Cacuso (2), Kiwaba Nzoji, Quinjy, Kinglas, Lombe. Again no nutritional intervention is deemed necessary.	Feb to April

Working with IMC	As IMC also have interventions in some of the selected areas, working with vaccination teams, health post and TBAs, combination with them was achieved.	Feb to April

3rd Quarter	**May to July**	
Trainings	Three of the five planned trainings were completed	May to July
SFC Malanje	Closed due to improved nutritional status in the population	*June 2003
Nutrition Survey	Malanje Lombe Global Malnut (z-score) 2.75 2.48 Severe Mal (z-score) 0.34 0.45 CMR (/10,000/day) 0.70 0.60 <5 MR (10,000/day) 2.02 1.58	*June 2003
MOH	The Ministry of Health assumed full responsibility for all nutrition programs in the city.	*June 2003
Rapid assessments	Concern participated in a rapid assessment to Massango. No intervention necessary.	*July 2003

4th Quarter	**August to October**	
Trainings	The five trainings planned were completed	August to October
Community activities	The teams were working well in the community and being to note a positive change in attitudes.	August to October
Rapid assessment	A rapid assessment was done to Cahombo. The situation was found to be very distressing. WFP began a blanket distribution	*October 2003
Application for No cost extension	As the planned activities were slower than assumed in evolving, a no cost extension was applied for.	*October 2003

5th Quarter	**November to January**	
Clean Campaigns	Acknowledging that activities were slower than anticipated, the clean campaigns were realized to try to address many objectives at once.	November to January
CHV activities	The CHVs continued to work towards reaching their objectives and consolidating the knowledge they were disseminating.	November to January
Rapid assessments	This rapid assessment was to Quizenga, in Cacuso. It was lead by OCHA and the Concern trained MoH team performed the nutritional aspect. No intervention was needed.	*December 2003
No Cost extension	The no cost extension was approved.	* December 2003
Mosquito nets	5,000 mosquito nets were obtained from WHO Luanda and transported to Malanje.	* December 2003

6th Quarter	**February to April**	
Clean campaings	These campaigns have proved very successful and were continued to re-inforce there message	February to April
Mosquito nets	The 5,000 nets received were continued to be impregnated and distributed .	February to April
CHV activities	The CHVs continued to work towards reaching their objectives and consolidating the knowledge they were disseminating.	February to April
Out Reach Team	This team who had been working with the nutrition aspect of the project, continued to measure children for malnutrition throughout the whole program	February to April

Logical Framework Matrix - Community Based Health/Nutrition Program in Post Emergency				
Malanje, Angola				
	Intervention Logic	Objectively Verifiable Indicators	Source of verification	Risks and Assumptions
Overall Objectives	1. To contribute to the reduction of mortality and morbidity in chronic post-emergency situation by increasing the capacity of communities to prevent diseases/malnutrition and improve the utilisation of basic health facilities.	1) Sufficient numbers of CHVs for the identified areas. 2) Adequate training and supervision of CHVs activities. 3) Adequate provision for treatment for treatment of moderately malnourished children	1) Regular surveys and monitoring of health situation. 2) Monthly reports. 3) Feeding center statistics.	

Project Purpose	1. Strengthen and expand the health services, delivered by CHV and develop a sustainable health systems that is complementing other local health facilities available i.e. TBAs, health posts, centers and hospitals. 2. Continue to deliver curative nutrition care for the malnourished children in Malanje and newly accessible areas subject to assessments. 3. Increase the health/nutritional knowledge amongst the population through participatory and practical health/nutritional educational and follow up. 4. Improve the coordination of humanitarian assistance	1) Increased number of people who are being advised by CHVs. 2) Increased number of people being referred to a clinic by CHVs. 3) Number of education session held per month and the number of care takers participating. 4) Improved coordination of health activities between NGOs, MoH, UNICEF and the community. 5) Number of children screened by the team/month	1) Monthly reports. 2) PRA with community. 3) CHVs statistics. 4) Number of participants in coordination meetings, regularity and decisions made. 5) Feeding center statistics.	1) Sufficient support and interest from MoH to take their responsibility in making it possible to improve the health care provided to the community. 2) Sufficient and timely funding to assure high quality program. 3) Active collaboration by community in identifying appropriate CHV for training. 4) Active and interested partners.

	provide to the community. 5. Strengthen a surveillance system through a permanent out reach team			
Results	1. An improved health/nutrition status amongst the targeted population. Improved capacity through increase knowledge in health/nutrition.	1) Decrease in preventable causes of malnutrition and child morbidity.	1) Feedback from community 2) CHVs information and monthly reports. Feedback from coordination meetings with other organisations.	1) Security allowing population to live under stable conditions 2) Continuity in the CHV team

Activities	1. Carry out a KAP study to serve as baseline information for future program evaluations. Identify and train CHVs in priority issues and using National module. 2. Supervise and coordinate the health activities in the community. 3. Provide supplementary feeding program for malnourished children through centers and a mobile distribution team to work in semi-accessible areas subject to assessment and security. 4. Monitor health/nutrition situation. 5. Distribute vegetable seeds to beneficiaries in SFC in order to encourage kitchen gardens.	1) Health/nutrition practices and believes amongst the targeted population is known. 2) 60 CHVs to be trained over the project periods. 3) Sufficient staffing at a Concern level to carry out supervision. 4) 2 distributing teams will provide the adequate service the first year and one team will remain the second year. 5) Regular assessments. 6) Each beneficiary will receive 60g of mixed vegetable seeds.	1) Number of kitchen gardens existing in the community.	